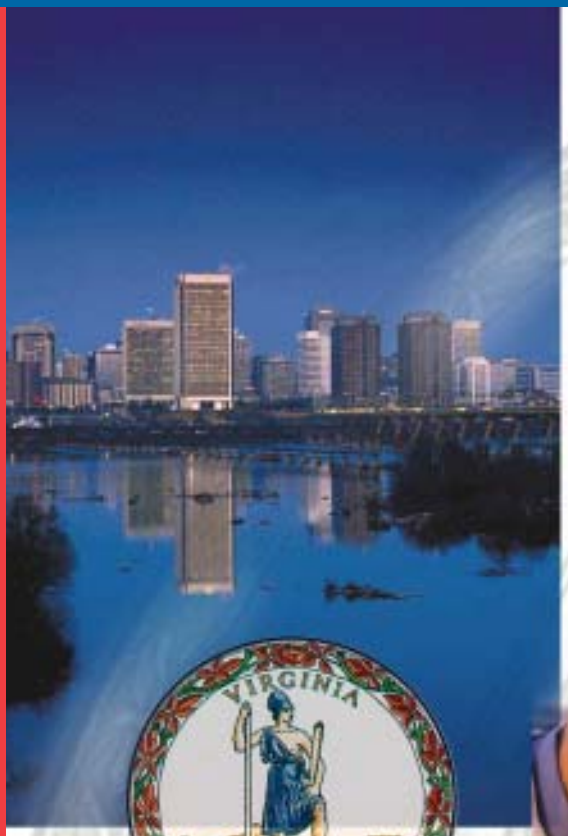
delmarva foundation



Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

UNICARE Health Plan of Virginia

Performance Improvement Project Validation

SFY 2004

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Performance Improvement Project Validation Summary UNICARE Health Plan of Virginia

Introduction

The Virginia Department of Medical Assistance Services (DMAS) requires all Managed Care Organizations (MCOs) participating in the Medallion II Program to have ongoing performance improvement projects (PIPs). The purpose of having MCOs conduct PIPs is to assist large systems in evaluating and improving health care processes that link to member outcomes.

PIP activity can offer states an insight into the strengths and weaknesses of a MCO's quality management system (QMS), as many projects typically run two to three years and use numerous resources internally and externally to target specific providers, enrollees, and others to show meaningful improvement in one measure. Minimum expectations for PIP activity is that the MCO is able to report on their performance in a specific area by producing valid data that can be collected, measured, analyzed, and reported on an annual basis.

DMAS is adhering to the regulations set forth in the Balanced Budget Act of 1997 requiring state Medicaid agencies to annually evaluate the quality of services furnished by each MCO to Medicaid enrollees.

In view of this requirement the DMAS established a contract with a quality improvement organization, Delmarva Foundation, Inc. (Delmarva), to serve as the External Quality Review Organization (EQRO) who will independently assess each Medallion II MCO's performance for the contract year of 2004.

Medallion II MCOs were required to submit one (1) asthma related PIP for the 2004 contract year. This report is a validation summary of UNICARE Health Plan of Virginia's (UNICARE) PIP activity that speaks to the soundness of the PIP design and whether DMAS can have confidence in the reported results. At a minimum, Medallion II MCOs were expected to submit a project report with baseline measurement to the EQRO for validation. All of the Medallion II MCOs used audited Health Plan Employer Data and Information Set (HEDIS®) measures to evaluate performance in specific areas related to national benchmarks. Final HEDIS® reports are sent to MCOs in the summer; therefore, the MCOs submitted final PIPs to the EQRO in the fall of 2004.

Methodology

UNICARE submitted their 2004 PIP on the National Committee's for Quality Assurance Quality Improvement Activity Form, which is the reporting tool that DMAS directed the MCOs to use when reporting their 2003 PIP activities. DMAS also agreed with the EQRO utilizing CMS' *Validation of PIPs* protocols as guidelines for review activities. To prepare each Medallion II MCO for the new validation requirements, Delmarva presented a four-hour program to orient the plans to the new BBA requirements and PIP Validation Protocols so that they would be familiar with the protocols used to evaluate their performance. CMS' Validation Protocols -"*Conducting and Validating Performance Improvement Projects"*- were presented to the MCOs in hardcopy during the PowerPoint presentation.

In addition to training nursing and health analysts in the QIA form, Delmarva staff received one eight-hour didactic educational program on the new EQR protocols. After developing a crosswalk between the QIA form and *Validating PIP Worksheet,* Delmarva staff developed review processes and worksheets using CMS' protocols as guidelines (2002). CMS' *Validation of PIPs* assist EQROs in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner, and a state agency could have a degree of confidence in the reported results.

Review Activity

After UNICARE submitted their 2004 PIP, *Asthma Control* electronically, a notice was sent from the EQRO to confirm receipt. The reviewers read the descriptions of UNICARE's study design and subsequent analyses that would help the plan develop strong, self-sustained interventions over time to achieve meaningful improvement.

A registered nurse, with over 20 years of QI and Managed Care experience, and over 4 years quality improvement project review experience, completed the validation activity. A Review Manager assessed each validation worksheet. A summary report was developed for each validation worksheet. A copy of UNICARE's PIP submission and PIP Validation Worksheets are included in addendum A1 and A2 respectively.

Findings

UNICARE's PIP was sound methodologically, and the descriptions followed the NCQA QIA form instructions for reporting. UNICARE's PIP targeted Medicaid enrollees between the ages of 5 and 56 with asthma who were continuously enrolled with a diagnosis of asthma during the measurement year.

The purpose of their 2004 PIP was to evaluate and improve performance in the appropriate use of asthma medications, a recognized standard of care for the proper management of asthma. UNICARE stated that "both over and under usage of asthma medications may lead to increased asthma complications, inpatient hospital stays and/or emergency room visits". The two goals of their 2004 PIP are:

1) To increase the percentage of enrollees with asthma who appropriately use asthma controller medications to at least 72.45%.
2) To decrease the percentage of enrollees with asthma who overuse reliever medications to 55.38%.

UNICARE completed their baseline measurement, established goals, developed interventions, and plans to re-measure and report their performance in one year.

Strengths and Opportunities for Improvement

Selection of study topic, problem statement, and indicators

Strengths: The study topic was approved by the DMAS. Providing full descriptions of the literature reviewed and internal data analyzed to choose the topic, UNICARE provided a clear and clinically appropriate rationale for the PIP. UNICARE used a HEDIS measure "Use of Appropriate Medications for People with Asthma" and a California Department of Health Services "Beta Agonist Overuse Measure" to evaluate performance that can be compared against benchmarks. UNICARE clearly identified inclusion and exclusion criteria for both measures.

Opportunities for Improvement: There was not a description of a problem statement that supports the rationale for the study.

Study population

Strengths: UNICARE used technical specifications from HEDIS to define its study population, which is an industry standard.

Sampling methodology

Strengths: No sampling was used. UNICARE included the entire eligible population in the PIP.

Data collection procedures

Strengths: The data to be collected and the sources of data were clearly specified as claims, encounter, and pharmacy data.

Opportunities for Improvement: Although UNICARE described the data collection methodology as a programmed pull from the claims, encounter, and pharmacy data, they did not describe how they assure the validity and reliability of all data collected over time. In addition, qualifications of UNICARE staff used to collect the data were not specified. A clear data analysis plan was not described.

Improvement strategies

Strengths: UNICARE described seven interventions planned for 2004 after baseline. It appeared that these interventions would be system wide and self-sustaining. UNICARE listed provider and enrollee/member barriers for each intervention proposed.

Data analysis and interpretation of study results

Strengths: Baseline data for both indicators was accurately and clearly reported.

Opportunities for Improvement: There was no evidence, however, of a clear description of analysis activities that lead to the identification of barriers related to improving performance in the two measures.

Evidence of real and sustained improvement

This is the baseline review year for this project using the new BBA requirements and PIP protocols.

Recommendations

To address opportunities for improvement, the reviewers make the final recommendations to strengthen future PIP reporting activities:

1) Submit a problem statement that supports the rationale for the study.
2) Describe efforts taken to assure the data is valid, including audits of the data collection, the plan of data analysis, and the qualifications of the staff responsible for collecting the data.
3) Submit a clear description of their analysis activities that determine the specific interventions planned to show meaningful improvement in the two indicators.

NCQA Quality Improvement Activity Form

Activity Name: Asthma Control-UNICARE Health Plan of Virginia

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

Asthma ranks among the most common chronic conditions in the United States. The 2002 national data consolidated by the Centers for Disease and Control (CDC) show an estimated 20.8 million persons in the United States afflicted with asthma and 1.9 million asthma-related hospital emergency room (ER) visits[1]. Analysis of prevalence reports ranks Asthma 6th among UNICARE Health Plan of Virginia (UNICARE) Medicaid diagnoses. The 2003 claims generated prevalence reports show 5,622 of UNICARE Medicaid members (11.5% of membership) are diagnosed with an asthma condition.

Appropriate use of asthma medications is critical to the proper management of an asthma condition. Both over and under-usage of asthma medications may lead to increase asthma complications, inpatient hospital stays, and/or ER visits. Given the importance of appropriate usage of asthma medications, UNICARE has established two specific quantified goals for its Asthma Control Quality Improvement Project (QIP):

1. To increase the rate of appropriate use of asthma controller medications (measure is HEDIS® measure: Use of Appropriate Medications for People with Asthma); and
2. To decrease the overuse of reliever medications. Specifically, to decrease the number of members who fill prescriptions for 8 or more short-acting beta agonist inhalation aerosol canisters per year[2].

References:

1. "National Center for Health Statistics: Asthma". Available at http://www.cdc.gov/nchs/fastats/asthma.htm
2. "DHS Asthma Measure Beta Agonist Overuse in the Medi-Cal Asthmatic Population". Source: California Department of Health Services (DHS).

B. Quantifiable Measure(s). List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	HEDIS® measure: Use of Appropriate Medications for People with Asthma
Numerator:	All eligible members filling at least one controller medication (inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, methylxanthines, long-acting beta-2 agonists) prescription during the measurement year.
Denominator:	Members age 5-56 years continuously enrolled during measurement year with a diagnosis of asthma based on administrative claims and pharmacy data.
First measurement period dates:	HEDIS® Reporting Year (RY) 2004
Baseline Benchmark:	≥71.07%
Source of benchmark:	2003 NCQA Mediciad 90th Percentile for HEDIS® measure: Use of Appropriate Medications for People with Asthma (source: 2003 NCQA State of Health Care [SOHC] Report)
Baseline goal:	The baseline goal for Measure #1 is to achieve the benchmark of 71.07% **or** a statistically significant increase ($p<0.05$). To achieve a statistically significant increase from the baseline rate, the goal is a rate of ≥ 72.45%.
Quantifiable Measure #2:	Overuse of reliever medication (8 or more canisters)
Numerator:	All eligible members filling at 8 or greater reliever medication (short acting beta-agonists) prescription during the measurement year.
Denominator:	Members age 5-56 years continuously enrolled during measurement year with a diagnosis of asthma based on administrative claims and pharmacy data. (Note: The same denominator is used for Measure #1 and Measure #2)
First measurement period dates:	HEDIS®RY 2004
Benchmark:	5 percentage point decrease from baseline rate.
Source of benchmark:	N/A
Baseline goal:	The baseline goal for Measure #2 is to improve performance by either achieving the benchmark goal of a 5% decrease from the baseline rate **or** achieving a decrease in rate that results in a statistically significant improved performance ($p<0.05$) .

C. Baseline Methodology.

C.1 Data Sources.

[ ] Medical/treatment records
[X] Administrative data:
[X] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[X] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[X] Other (list and describe): (Measure #2)

Reliever overuse is defined and outlined in the California Department of Health Services (DHS) document, "Beta Agonist Overuse in the MediCal Asthmatic Population", numerator data pull based on NDC code list provided DHS document.

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):-B3 (Phone Survey)

If administrative, check all that apply:
[X] Programmed pull from claims/encounter files of all eligible members-Measure #1 & #2
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[X] Pharmacy data- Measure #1 & #2
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

_____

_____

C.3 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*
N/A				

C.4 Data Collection Cycle.	Data Analysis Cycle.
[X] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _____ _____	[X] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ _____

C.5 Other Pertinent Methodological Features. Complete only if needed.

N/A

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate:

- Measure and time period covered
- Type of change
- Rationale for change
- Changes in sampling methodology, including changes in sample size, method for determining size and sampling method
- Any introduction of bias that could affect the results

N/A_____

_____

_____

_____

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure: HEDIS® Measure: Appropriate Use Medications for People with Asthma: Medallion II

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
HEDIS® RY2004	***Baseline:***	170	265	**64.15%**	≥ 71.07%	N/A	Chi-Square Test at p<0.05. to be used to compare baseline to remeasurement #1
	Remeasurement 1:					≥ 72.45%	
	Remeasurement 2:						

#2 Quantifiable Measure: Rate of Overuse of Reliever Medication: Medallion II

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
HEDIS® RY2004	***Baseline:***	160	265	**60.38%**	5 percentage point decrease:	N/A	
HEDIS® RY2005	Remeasurement 1:					55.38 %	
HEDIS® RY2006	Remeasurement 2:						

* If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle
Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That the Analysis Covers.

Baseline Measurement: HEDIS® RY2004
1st Remeasurement: HEDIS® RY2005
2nd Remeasurement: HEDIS® RY2006

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

B.1 For the quantitative analysis, include the analysis of the following:
- Comparison with the goal/benchmark
- Reasons for changes to goals
- If benchmarks changed since baseline, list source and date of changes
- Comparison with previous measurements
- Trends, increases or decreases in performance or changes in statistical significance (if used)
- Impact of any methodological changes that could impact the results
- For a survey, include the overall response rate and the implications of the survey response rate

B.2 For the qualitative analysis, describe any analysis that identifies causes for less than desired performance (barrier/causal analysis) and include the following:
- Techniques and data (if used) in the analysis
- Expertise (e.g., titles; knowledge of subject matter) of the work group or committees conducting the analysis
- Citations from literature identifying barriers (if any)
- Barriers/opportunities identified through the analysis
- Impact of interventions

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
3/04	X	Annual physician mailing of Asthma Disease Management Physician Toolkit, which includes the following: UNICARE Medallion Asthma program description, member educational materials (asthma education brochures and an Asthma action plan), and the National Heart, Lung, and Blood Institute (NHLBI) asthma clinical practice guidelines. (537 packets were sent to physicians)	• Lack of physician knowledge of Blue Cross asthma materials/resources available to members and providers. • Lack of physician knowledge of recommended Asthma clinical practice guidelines (CPG).
1st Qtr 2004 - present	X	Asthma member incentive gift. Members receive a gift for submitting a physician signed form indicating an asthma plan was developed for the member.	• Lack of member knowledge of how to treat asthma warning signs, and asthma flare-ups. • Lack of member knowledge of asthma self-management skills.
2nd Qtr 2004	X	Biannual fax/mailing of asthmatic patient list to physicians. The list contains health assessment information based on medical and pharmacy claims review, which defines the asthma risk level of each patient on list. (286 physicians faxes were sent)	• Lack of physician knowledge of patients in need of additional support with asthma management.
7/04 and 9/04	X	Biannual member mailing of asthma member education toolkit in English and Spanish. (1,648 English and 492 Spanish mailed)	• Lack of member knowledge of how to treat asthma warning signs, and asthma flare-ups. • Lack of member knowledge of asthma self-management skills.
Planned 3rd Qtr 2004	X	Outreach Call Center (OCC) calls to members identified with moderate and severe risk asthma in order to monitor members' health status, adherence to asthma treatment plan and screening for case management.	• Lack of member knowledge of how to treat asthma warning signs, and asthma flare-ups. • Lack of member knowledge of asthma self-management skills.

Planned 3rd Qtr 2004	X	Referral to UNICARE Community Resource Centers (CRCs). CRCs then refer member to local community health education classes and/or community resources related to asthma.	• Lack of member knowledge of how to treat asthma warning signs, and asthma flare-ups. • Lack of member knowledge of asthma self-management skills. • Lack of member knowledge of resources available to help manage asthma condition. • Lack of member knowledge of linguistically appropriate asthma resources available to members. • Lack of member knowledge of options available to help address transportation issues.
Planned 3rd Qtr 2004	X	Case management for identified severe risk asthmatics.	• Lack of member knowledge of how to treat asthma warning signs, and asthma flare-ups. • Lack of member knowledge of asthma self-management skills.

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

Performance Improvement Project Validation Worksheet

Project Information
MCO/PHP Name and State: UNICARE Health Plan of Virginia (UNICARE)
PIP Topic: Asthma Control
Dates in PIP Study Period: 1/1/2003 to 12/31/2003 **Dates of Review Period:** 1/1/2003 to 12/31/2003 **Note:** UNICARE began serving Medallion II enrollees in 2002.

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY					
Step 1. REVIEW THE SELECTED STUDY TOPIC(S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?	☒	☐	☐	UNICARE used Medicaid MCO specific and national data in selecting its study topic. Analysis of MCO prevalence reports ranks asthma as 6th among Medicaid diagnoses. Claims generated reports from 2003 revealed 11.5% of UNICARE Medicaid enrollees have been diagnosed with an asthma condition. Nationally 20.8 million persons in the United States are afflicted with asthma and 1.9 million emergency room visits are asthma related. UNICARE also provided full citations for literature.	QAPI RE2Q1 QAPI RE2Q2, 3,4 QIA S1A1
1.2 Did the MCO s/PHP s PIP address a broad spectrum of key aspects of enrollee care and services?	☒	☐	☐	UNICARE is evaluating the rate of appropriate use of asthma controller medications and the number of filled short-acting beta agonist inhalation aerosol canisters among eligible asthmatics, which would evaluate services provided by providers over time. DMAS also approved this project's topic.	QAPI RE2Q1 QIA S1A2
1.3 Did the MCOs/PHPs PIP include all enrolled populations; i.e., did not exclude certain enrollees such as with those with special health care needs?	☒	☐	☐	UNICARE followed the HEDIS eligible population description for Medicaid that contained inclusion and exclusion criteria. DMAS also approved this project's topic.	QAPI RE2Q1 QIA S1A2

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)

Assessment Component 1

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components are present.

Recommendations

Step 2: REVIEW THE STUDY QUESTION(S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	☐	☒	☐	The PIP did not contain a clear problem statement – to explain to the reviewers how this specific problem was identified for improvement for the Medallion II population at UNICARE Health Plan of Virginia.	QIA S1A3

Assessment Component 2

☐ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☒ Unmet -None of the required components are present.

Recommendations

Describe a problem statement that explains why UNICARE Health Plan of VA chose this project for meaningful improvement in the Medallion II population.

Step 3: REVIEW SELECTED STUDY INDICATOR(S)					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	☒	☐	☐	Two indicators were identified for this study: use of appropriate medications for people with asthma (a HEDIS measure) and overuse of reliever medication. All indicators were objective, clearly defined, and based on current clinical knowledge.	QAPI RE3Q1, QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	☒	☐	☐	Use of appropriate asthma medications has been demonstrated to improve long-term control for individuals with asthma and as such serves as a proxy measure for changes in health status.	QAPI RE3Q9 QIA S1B1
Assessment Component 3 ☒ Met – All required components are present. ☐ Partially Met – Some, but not all components are present. ☐ Unmet -None of the required components are present					
Recommendations					

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	☒	☐	☐	UNICARE defined all Medicaid enrollees for this study as those members age 5-56 years continuously enrolled during the measurement year with a diagnosis of asthma based on administrative claims and pharmacy data. The plan used HEDIS technical specifications for the eligible population requirements and this meets requirements.	QAPI RE2Q1, QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	☒	☐	☐	The plan used HEDIS technical specifications for the eligible population requirements and this meets requirements.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C
Assessment Component 4 ☒ Met – All required components are present. ☐ Partially Met – One, but not all components are present. ☐ Unmet -None of the required components are present.					
Recommendations					

Step 5: REVIEW SAMPLING METHODS					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐	☐	☒	No sampling was used. UNICARE included the entire eligible population in the PIP.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias? *Specify the type of sampling or census used:*	☐	☐	☒		QAPI RE5Q1.3b-c QIA S1C2
5.3 Did the sample contain a sufficient number of enrollees?	☐	☐	☒		QAPI RE5Q1.3b-c QIA S1C2
Assessment Component 5 ☐ Met – All required components are present. ☐ Partially Met – Some, but not all components are present. ☐ Unmet -None of the required components are present. ☒ Not applicable.					
Recommendations					

Step 6: REVIEW DATA COLLECTION PROCEDURES					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	☒	☐	☐	The "Quantifiable Measures" and "Baseline Methodology" sections specified the data to be collected for the numerator and the denominator for each indicator. For indicator #1 HEDIS data requirements were specified. For indicator #2 the denominator was specified as the same as for indicator #1. The numerator was well-defined specifying eight or greater reliever medication prescriptions, based upon the NDC code list provided by the California Department of Health Services, during the measurement year.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data	☒	☐	☐	Sources of data were clearly identified to include: claims/encounter data and pharmacy data.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	☐	☒	☐	The data collection methodology for indicators #1 and #2 was listed as a programmed pull from claims/encounter files of all eligible members as well as pharmacy data. It is unclear whether pharmacy data will be collected manually or through an automated system. Data collection was identified as once a year. There was no evidence of a plan to audit data to ensure validity and reliability for any indicator or an estimation of the degree of completeness of data.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3

Step 6: REVIEW DATA COLLECTION PROCEDURES					
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	☐	☒	☐	The PIP did not include a plan to ensure that data collection tools provided consistency and accuracy in data collection.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 Did the study design prospectively specify a data analysis plan?	☐	☒	☐	Timeframe for data analysis cycle was specified as once a year. The PIP did not describe a prospective plan for data analysis.	QAPI RE5Q1.2
6.6 Were qualified staff and personnel used to collect the data?	☐	☒	☐	The PIP did not specify the qualifications of staff/personnel used to collect the data.	QAPI RE4Q4

Assessment Component 6

☐ Met – All required components are present.

☒ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components are present.

Recommendations

- Provide a description of how UNICARE ensures that the collection of data is valid and reliable data over time.
- Provide a brief description of staff qualifications that collect and analyze the data for the indicators.
- Describe the data analysis plan.

Step 7: ASSESS IMPROVEMENT STRATEGIES					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	☒	☐	☐	The plan described seven interventions planned for 2004 after baseline. It appeared that these interventions would be system wide and self – sustaining. UNICARE listed provider and enrollee/member barriers for each intervention proposed.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 QIA S4.2 QIA S4.3

Assessment Component 7.

☒ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components are present.

☐ Not applicable.

Recommendations

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐	☒	☐	The data analysis cycle was specified as once a year. The PIP did not provide a clear description of the qualitative and quantitative activities that their Quality Management System undertook to analyze their baseline performance and to develop interventions targeted at improving performance in the two indicators.	QAPI RE4Q4 QIA III
8.2 Did the MCO/PHP present numerical PIP results and findings accurately and clearly?	☒	☐	☐	The "Data/Results Table" accurately and clearly identified the baseline rate, MCO goal, and comparison benchmark for each indicator.	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	☐	☒	☐	As stated, there was no clear description of an analysis of the initial measurement.	QAPI RE7Q2 QIA S1C4 QIA S2.1
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	☐	☐	☒	This is not applicable since the PIP was initiated in 2003 with the collection of baseline data.	QIA S2.2

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS
Assessment Component 8 ☐ Met – All required components are present. ☒ Partially Met – Some, but not all components are present. ☐ Unmet -None of the required components are present. ☐ Not applicable.
Recommendations ➢ Submit a clear description of their analysis activities that determine the specific interventions planned to show meaningful improvement in the two indicators.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	☐	☐	☒	Since this PIP was initiated in 2003 only baseline data was collected. This component is, therefore, not applicable for this review period.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1 QIA S3.3 QIA S3.4
9.2 Was there any documented quantitative improvement in processes or outcomes of care?	☐	☐	☒		QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	☐	☐	☒		QIA S3.2
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	☐	☐	☒		QIA S2.3

Assessment Component 9

☐ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components are present.

☒ Not applicable.

Step 9: ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT
Recommendations

Step 10: ASSESS SUSTAINED IMPROVEMENT					
Component/Standard	**Y**	**N**	**N/A**	**Comments**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐	☐	☒	Since this PIP was initiated in 2003 only baseline data was collected. This component is, therefore, not applicable for this review period.	QAPI RE2SQ3 QIA II, III

Assessment Component 10

☐ Met – All required components are present.

☐ Partially Met – Some, but not all components are present.

☐ Unmet -None of the required components are present.

☒ Not applicable.

Recommendations

Key Findings
1. Strengths of the PIP submission ➢ All indicators were objective, clearly defined, and based on current clinical knowledge. ➢ UNICARE made excellent use of published data from the National Committee for Quality Assurance (HEDIS measures) and California Department of Health Services (reliever medication listing) in operationally defining numerator and denominator for each indicator. ➢ They are using the entire eligible population in this study.
2. Best Practices
3. Potential /significant issues experienced by MCO The plan did not describe issues in their PIP.
4. Actions taken by MCO to address issues
5. Recommendations for next project submission: ➢ Describe a problem statement that explains why UNICARE Health Plan of VA chose this project for meaningful improvement in the Medallion II population. ➢ Provide a description of how UNICARE ensures that the collection of data is valid and reliable data over time. ➢ Provide a brief description of staff qualifications that collect and analyze the data for the indicators. ➢ Describe the data analysis plan. ➢ Submit a clear description of their analysis activities that determine the specific interventions planned to show meaningful improvement in the two indicators.